

managed in such a manner that the cash flows from the aggregated assets are available to help mature the liabilities from the blocks of business that have been aggregated;

2. aggregate the results of asset adequacy analysis of one or more products or lines of business, the reserves for which prove through analysis to be redundant, with the results of one or more products or lines of business, the reserves for which prove through analysis to be deficient. The appointed actuary must be satisfied that the asset adequacy results for the various products or lines of business for which the results are so aggregated:

a. are developed using consistent economic scenarios; or

b. are subject to mutually independent risks, i.e., the likelihood of events impacting the adequacy of the assets supporting the redundant reserves is completely unrelated to the likelihood of events impacting the adequacy of the assets supporting the deficient reserves;

3. in the event of any aggregation, the actuary must disclose in his or her opinion that such reserves were aggregated on the basis of method §2117.A.1 or method §2117.A.2.a or b, whichever is applicable, and describe the aggregation in the supporting memorandum.

B. Selection of Assets for Analysis

1. The appointed actuary shall analyze only those assets held in support of the reserves which are the subject for specific analysis, hereafter called "specified reserves." A particular asset, or portion thereof, supporting a group of specified reserves cannot support any other group of specified reserves. An asset may be allocated over several groups of specified reserves. The annual statement value of the assets held in support of the reserves shall not exceed the annual statement value of the specified reserves, except as provided in §2117.C. If the method of asset allocation is not consistent from year to year, the extent of its inconsistency should be described in the supporting memorandum.

C. Use of Assets Supporting the Interest Maintenance Reserve and the Asset Valuation Reserve

1. An appropriate allocation of assets in the amount of the Interest Maintenance Reserve (IMR), whether positive or negative, must be used in any asset adequacy analysis. Analysis of risks regarding asset default may include an appropriate allocation of assets supporting the Asset Valuation Reserve (AVR). These AVR assets may not be applied for any other risks with respect to reserve adequacy. Analysis of these and other risks may include assets supporting other mandatory or voluntary reserves available to the extent not used for risk analysis and reserve support.

2. The amount of the assets used for the AVR must be disclosed in the Table of Reserves and Liabilities of the opinion and in the memorandum. The method used for selecting particular assets, or allocated portions of assets, must be disclosed in the memorandum.

D. Required Interest Scenarios. For the purpose of performing the asset adequacy analysis required by this regulation, the qualified actuary is expected to follow standards adopted by the Actuarial Standards Board; nevertheless, the appointed actuary must consider in the analysis the effect of at least the following interest rate scenarios:

1. level with no deviation;
2. uniformly increasing over 10 years at 1/2 percent per year and then level;
3. uniformly increasing at 1 percent per year over five years and then uniformly decreasing at 1 percent per year to the original level at the end of 10 years and then level;
4. an immediate increase of 3 percent and then level;
5. uniformly decreasing over 10 years at 1/2 percent per year and then level;
6. uniformly decreasing at 1 percent per year over five years and then uniformly increasing at 1 percent per year to the original level at the end of 10 years and then level; and
7. an immediate decrease of 3 percent and then level.

For these and other scenarios which may be used, projected interest rates for a five-year Treasury Note need not be reduced beyond the point where the five-year Treasury yield would be at 50 percent of its initial level. The beginning interest rates may be based on interest rates for new investments as of the valuation date similar to recent investments allocated to support the product being tested or be based on an outside index, such as Treasury yields, of assets of the appropriate length on a date close to the valuation date. Whatever method is used to determine the beginning yield curve and associated interest rates should be specifically defined. The beginning yield curve and associated interest rates should be consistent for all interest rate scenarios.

E. Documentation. The appointed actuary shall retain on file, for at least seven years, sufficient documentation so that it will be possible to determine the procedures followed, the analyses performed, the basis for assumptions, and the results obtained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:162.1.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:194 (February 1994).

Chapter 23. Regulation 48C Standardized Claims Forms

§2301. Purpose

A. The purpose of this regulation is to standardize the forms used in the billing and reimbursement of health care, reduce the number of forms utilized and increase efficiency in the reimbursement of health care through standardization.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2303. Definitions

CDT-1 Codes☐the current dental terminology prescribed by the American Dental Association.

CPT-4 Codes☐the current procedural terminology published by the American Medical Association.

HCFA☐the Federal Health Care Financing Administration of the U.S. Department of Health and Human Services.

HCFA for UB92☐the health insurance claim form published by HCFA for use by institutional care providers.

HCFA Form 1500☐the health insurance claim form published by HCFA for use by health care providers.

HCPCS☐HCFA's common procedure coding system which is based upon the AMA's *Physician Current Procedural Terminology, Fourth Edition* (CPT-4).

1. **HCPCS Level 1 Codes**☐the AMA's CPT-4 codes with the exception of anesthesiology services.

2. **HCPCS Level 2 Codes**☐the codes for physician and nonphysician services are not included in COT-4.

Health Care Provider☐

1. an acupuncturist licensed under R.S. 37:1356-1360;
2. a certified registered nurse anesthetist licensed under R.S. 37:930;
3. a chiropractor licensed under R.S. 37:2801-2830.7;
4. a dentist licensed under R.S. 37:751-794;
5. a dietician and nutritionist licensed under R.S. 37:3081-3093 and 36:259U;
6. durable medical equipment suppliers;
7. an emergency medical technician licensed under R.S. 40:1231-1232;
8. a general health clinic (excluding early periodic screening diagnosis treatment clinics) certified by the Louisiana Department of Health and Hospitals;
9. a hearing aid dealer licensed under R.S. 37:2441-2465;
10. a licensed practical nurse licensed under R.S. 37:961;
11. a mental health counselor licensed under R.S. 37:1101-1115;
12. a mental health clinic licensed under R.S. 28:567;
13. a midwife licensed under R.S. 37:3240-3257;
14. an occupational therapist licensed under R.S. 37:3001-3014;
15. an optometrist licensed under R.S. 37:1052;
16. a physical therapist and physical therapist assistant licensed under R.S. 37:2401-2419;
17. a physician licensed under R.S. 37:1261-1292;

18. a physician assistant licensed under R.S. 37:1360.21-27;

19. a podiatrist licensed under R.S. 37:611-628;

20. a psychologist licensed under R.S. 37:2351-2370;

21. a registered nurse licensed under R.S. 37:911-931;

22. a rehabilitation center licensed under 42:CFR 405.1701Q;

23. a respiratory therapist licensed under R.S. 37:3351-3361;

24. a social worker licensed under R.S. 37:2701-2718;

25. a speech pathologist and audiologist licensed under R.S. 2651-2665;

26. a substance abuse counselor licensed under R.S. 37:3371-3384;

27. a substance abuse prevention/treatment program licensed under R.S. 40:1058.1-1058.3;

28. a free standing ambulatory surgical center licensed under R.S. 40:2131-2141;

29. any other health care providers as licensed by the state of Louisiana;

ICD-9-CM Codes☐the disease codes in the *International Classification of Diseases, Ninth Revision*, clinical modifications published by the U.S. Department of Health and Human Services.

Institutional Care Provider☐

1. an adult day health care provider licensed under R.S. 46:1971-1980;
2. an ambulatory surgical center licensed under R.S. 40:2131-2143;
3. a drug screening laboratory licensed under R.S. 49:1111-1113, 1115-1118, 1121, 1122, and 1125.
4. an end stage renal dialysis facility under 42:CFR 405.2100;
5. a home health agency licensed under R.S. 40:2009.31-2009.40;
6. a hospice licensed under R.S. 40:2181-2191;
7. a hospital licensed under R.S. 40:2100-2114;
8. a nursing home licensed under R.S. 40:2009;
9. a residential care/community group home or residential facility licensed under R.S. 46:51, 1401-1411, and 28:1-284;
10. any other institutional care provider as licensed by the state of Louisiana.

J512 Form☐the uniform dental claim form approved by the American Dental Association for use by dentists.

Medicaid☐Title XIX of the Federal Social Security Act.

Medicare☐Title XVIII of the Federal Social Security Act.

Revenue Codes—The codes established for use by institutional care providers by the National Uniform Billing Committee.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2305. Applicability and Scope

A. Except as otherwise specifically provided, the requirements of this regulation apply to all issuers of health care policies or contracts of insurance, administrators of self-funded employee benefit plans, and other forms of insurance and entitlement programs under Title XVIII and Title XIX involved in the reimbursement of health care expenses, and all providers of health care licensed by the state.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2307. Requirements for Use of HCFA Form 1500

A. Health care providers, other than dentists, shall use the HCFA Form 1500 and instructions provided by HCFA for use of the HCFA Form 1500 when billing patients or their representatives for reimbursement of claims with insurers for professional services.

B. An issuer may not require a health care provider to use any coding system for the initial filing of claims for health care services other than the following:

1. HCPCS Codes; and
2. ICD-9-CM Codes.

C. An issuer may not require a health care provider to use any other descriptor with a code or to furnish additional information with the initial submission of a HCFA Form 1500 except under the following circumstances:

1. when the procedure code used describes a treatment or service which has not been included in CPT-4 or is billed under an unlisted procedure code and a description of services is necessary; or
2. when the procedure code is followed by the CPT-4 modifier 22, 47, 50, 51, 52, 62, 66, 77, or 99; or
3. when required by a contract/agreement between the issuer and health care provider; or
4. as otherwise required by federal regulation; or
5. as otherwise required by the Office of Workers' Compensation of the Louisiana Department of Labor.

D. Use of HCFA Form 1500 shall be effective July 1, 1994 for all issuers excluding rehabilitation facilities reimbursed by Louisiana Medicaid which will have an effective date of January 1, 1995.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2309. Requirements for Use of HCFA Approved Form UB92

A. Institutional care providers shall use the HCFA approved Form UB92 and instructions provided by HCFA for use of the HCFA approved UB92 when billing patients or their representatives directly and filing claims with issuers for professional services.

B. An issuer may not require an institutional care provider to use any coding system for the initial filing of claims for health care services other than the following:

1. ICD-9-CM Codes;
2. Revenue Codes;
3. HCPCS Level I Codes;
4. HCPCS Level 2 Codes; and
5. if charges include direct service of a health care provider, the information outlined in §2307 of this regulation.

C. Use of the HCFA approved Form UB92 shall be effective July 1, 1994 for all issuers excluding nursing facilities, adult day health care facilities, and residential care facilities reimbursed by Louisiana Medicaid which shall have an effective date of January 1, 1996.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2311. Requirements for Use of J512 Form

A. A dentist shall use the J512 Form and instructions provided by the American Dental Association CDT-1 for use of the J512 Form by billing patients or their representatives directly and filing claims with issuers for professional services.

B. An issuer may not require a dentist to use any other code other than the CDT-1 codes for the initial filing of claims for dental care services.

C. Use of J512 Form shall be effective July 1, 1994 for all issuers excluding reimbursement to dentists reimbursed by Louisiana Medicaid which shall have an effective date of January 1, 1995.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

§2313. General Provisions

A. A health care provider or institutional care provider shall file a claim in a manner consistent with the requirements of this regulation which are:

1. a paper form printed on 8.5-inch paper;
2. an electronically transmitted claim.

B. An issuer shall accept a form which is submitted in compliance with this regulation for the processing of the insured's or beneficiaries' claims.

C. Nothing in this regulation shall prevent an issuer from requesting additional information which is not contained on the forms required under this regulation to determine eligibility of the claim for payment if required under the terms of the policy or certificate issued to the claimant.

D. All health care providers and institutional care providers shall:

1. use the most current editions of the HCFA approved Form 1500, HCFA Form UB92, or J512 Form and most current instructions for these forms in the billing of patients or their representatives and filing claims with issuers;

2. modify their billing practices to encompass the coding charges for all billing and claim filing by the effective date of the changes set forth by the developers of the forms, codes, and procedures required under this regulation.

E. Submitted billing and claim filing forms not complying with the minimum requirements of this regulation shall be considered to be in noncompliance with the regulation and issuers shall have the right to deny reimbursement until such time as the forms are in compliance with this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S.22:10, 22:213(A)(14), and 22:3016(C) of the *Insurance Code*.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:195 (February 1994), amended LR 20:1126 (October 1994).

Chapter 25. Regulation 49CBilling Audit Guidelines

§2501. Purpose

A. The purpose of this regulation is to provide for the reasonable standardization of statewide billing audit guidelines for health care providers and payers; and to provide for related matters. These rules are based, at least in part, on the National Health Care Billing Audit Guidelines and variances in order to comply with R.S. 22:12.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2503. Applicability and Scope

A. This regulation shall apply to health care providers and payers. The provider and/or payer involved in the billing audit shall be responsible for the conduct and results of the billing audit, whether conducted by an employee or by contract with another firm. This means that the provider and payer shall:

1. exercise proper supervision of the process to ensure that the audit is conducted according to the spirit of the regulations set forth here;

2. be aware of the actions being undertaken by the auditor in connection with the billing audit and its related activities; and

3. take prompt remedial action if inappropriate behavior by the auditor is discovered.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 20:311 (March 1994).

§2505. Definitions

A. For purposes of this regulation:

Ambulatory Surgical Center Ambulatory surgical center as defined in R.S. 40:2133(A).

Billing Audit A process to determine whether data in a provider's medical record documents or supports services listed on a provider's bill. Billing audit does not mean a review of medical necessity of services provided, cost or pricing policy of a facility, and adjustments for "usual and customary".

Health Record which Shall Mean Medical Record Any compilation of charts, records, reports, documents, and other memoranda prepared by a health care provider, wherever located, to record or indicate the past or present condition, sickness, or disease, and treatment rendered, physical or mental, of a patient.

Historic Error Rate The average error found during all audits conducted by external qualified billing auditors during the preceding calendar year. It shall be calculated by totaling the net adjustments made to all accounts audited by external qualified billing auditors during that year and dividing that total by the total amount claimed by the audited party to be due on those accounts immediately preceding the audit. This calculation results is an average error rate for all externally audited cases expressed as a percentage.

Hospital Hospital as defined in R.S. 40:2102(A).

Patient A natural person who receives or should have received health care from a health care provider, under a contract, expressed or implied.

Qualified Billing Auditor A person employed by a corporation or firm that is recognized as competent to perform or coordinate billing audits and that has explicit policies and procedures protecting the confidentiality of all the patient information in their possession and disposal of this information.

Unbilled Charges The volume of services indicated on a bill is less than the volume identified in a provider's health record documentation; also known as undercharges.

Unsupported or Undocumented Charges The volume of services indicated on a bill exceeds the total volume identified in a provider's health record documentation; also known as overcharges.

AUTHORITY NOTE: Promulgated in accordance with Act 664 of the 1993 Regular Legislative Session and R.S. 22:12.